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2005 STATE OF ILLINOIS DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES (FISCAL YEAR 2005)

IMPORTANT NOTICE

THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I.	IDPH Facility ID Number: 0034256	II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER
	Facility Name: MASON CITY AREA NURSING HOME Address: 520 NORTH PRICE AVENUE, BOX #32 MASON CITY 62664 Number City Zip Code County: Mason Telephone Number: (217) 482-5022 Fax # ()	I have examined the contents of the accompanying report to the State of Illinois, for the period from 1/01/05 to 12/31/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge. Intentional misrepresentation or falsification of any information
	HFS ID Number: 371168043001	in this cost report may be punishable by fine and/or imprisonment.
	XX VOLUNTARY, NON-PROFIT PROPRIETARY GOVERNMENTAL	Officer or Administrator of Provider (Signed) (Type or Print Name) Joyce Conrady (Title) Administrator
	xxCharitable Corp.IndividualStateTrustPartnershipCounty	(Signed)
		Paid Preparer (Print Name and Title) (Firm Name Enterprises & Address) (Telephone) MAIL TO: BUREAU OF HEALTH FINANCE
	In the event there are further questions about this report, please contact: Name: Craig Ater Telephone Number: (309)823-7135	ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES 201 S. Grand Avenue East Springfield, IL 62763-0001 Phone # (217) 782-1630

Page 2

0034256 1/01/05 **Ending:** 12/31/05 Facility Name & ID Number MASON CITY AREA NURSING HOME **Report Period Beginning:** III. STATISTICAL DATA D. How many bed-hold days during this year were paid by the Department? A. Licensure/certification level(s) of care; enter number of beds/bed days, (Do not include bed-hold days in Section B.) (must agree with license). Date of change in licensed beds E. List all services provided by your facility for non-patients. (E.g., day care, "meals on wheels", outpatient therapy) none Beds at Licensed Beginning of Licensure Beds at End of **Bed Days During** F. Does the facility maintain a daily midnight census? Report Period Level of Care Report Period Report Period G. Do pages 3 & 4 include expenses for services or Skilled (SNF) 12,045 investments not directly related to patient care? **33** Skilled Pediatric (SNF/PED) 2 YES NO 3 3 Intermediate (ICF) 33 12,045 4 Intermediate/DD H. Does the BALANCE SHEET (page 17) reflect any non-care assets? **Sheltered Care (SC)** 31 11,315 5 YES NO 6 ICF/DD 16 or Less 6 I. On what date did you start providing long term care at this location? 7 97 TOTALS 35,405 Date started 1989 J. Was the facility purchased or leased after January 1, 1978? B. Census-For the entire report period. YES XX Level of Care Patient Days by Level of Care and Primary Source of Payment K. Was the facility certified for Medicare during the reporting year? Medicaid YES XX If YES, enter number Recipient **Private Pay** Other Total of beds certified and days of care provided 2.134 SNF 10,707 9,428 2,134 22,269 8 SNF/PED Medicare Intermediary Mutual of Omaha 10 ICF 10 11 ICF/DD 11 IV. ACCOUNTING BASIS 12 SC 5,669 12 0 5,669 0 **MODIFIED** 13 DD 16 OR LESS 13 ACCRUAL xx CASH* CASH* 14 TOTALS 10,707 15.097 2.134 27,938 14 Is your fiscal year identical to your tax year? YES C. Percent Occupancy. (Column 5, line 14 divided by total licensed Tax Year: Fiscal Year: * All facilities other than governmental must report on the accrual basis. bed days on line 7, column 4.) 78.91%

STATE OF ILLINOIS
__#__0034256 Page 3 12/31/05 **Facility Name & ID Number** MASON CITY AREA NURSING HOME **Report Period Beginning:** 1/01/05 **Ending:**

	V. COST CENTER EXPENSES (through				llar)		D 1 (# 1			EOD OHE	HOE ONLY	
	O		Costs Per Genera	0	Total	Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	
	Operating Expenses	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total	0	10	
4	A. General Services	1	2	3	4	5	6 218,810	7	8	9	10	+-
1	Dietary	207,708	11,102		218,810				218,810			1
2	Food Purchase	60.00	135,886		135,886		135,886		135,886			2
3	Housekeeping	68,907	17,750		86,657		86,657		86,657			3
4	Laundry	50,981	7,282		58,263		58,263		58,263			4
5	Heat and Other Utilities			67,100	67,100		67,100		67,100			5
6	Maintenance	56,567	26,434	30,251	113,252		113,252		113,252			6
7	Other (specify):*											7
8	TOTAL General Services	384,163	198,454	97,351	679,968		679,968		679,968			8
	B. Health Care and Programs											
	Medical Director			9,000	9,000		9,000		9,000			9
	Nursing and Medical Records	1,118,263	92,162	2,661	1,213,086		1,213,086		1,213,086			10
10a	Therapy		64,089	171,187	235,276	(80,630)	154,646		154,646			10a
11	Activities	52,017	2,908		54,925		54,925		54,925			11
12	Social Services	17,272	31	1,496	18,799		18,799		18,799			12
13	CNA Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,187,552	159,190	184,344	1,531,086	(80,630)	1,450,456		1,450,456			16
	C. General Administration											
17	Administrative	65,554			65,554		65,554		65,554			17
18	Directors Fees											18
19	Professional Services			108,585	108,585		108,585	(1,385)	107,200			19
20	Dues, Fees, Subscriptions & Promotions			55,331	55,331	(36,135)	19,196	(7,852)	11,344			20
21	Clerical & General Office Expenses	158,496	11,590	15,834	185,920		185,920		185,920			21
22	Employee Benefits & Payroll Taxes	,	,	384,771	384,771		384,771		384,771			22
23	Inservice Training & Education			1,999	1,999		1,999		1,999			23
24	Travel and Seminar			5,185	5,185		5,185	(3,186)	1,999			24
25	Other Admin. Staff Transportation			,	,		,	())	,			25
26	Insurance-Prop.Liab.Malpractice			108,110	108,110		108,110		108,110			26
	Other (specify):*			10	10		10		10			27
28	TOTAL General Administration	224,050	11,590	679,825	915,465	(36,135)	879,330	(12,423)	866,907			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	1,795,765	369,234	961,520	3,126,519	(116,765)	3,009,754	(12,423)	2,997,331			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number MASON CITY AREA NURSING HOME

#0034256

Report Period Beginning:

1/01/05

Ending:

Page 4 12/31/05

V. COST CENTER EXPENSES (continued)

			Cost Per Gener	al Ledger		Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF	USE ONLY	T
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			114,169	114,169		114,169		114,169			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			2,744	2,744		2,744	(2,744)				32
33	Real Estate Taxes			2,517	2,517		2,517	(2,517)				33
34	Rent-Facility & Grounds							(2,429)	(2,429)			34
35	Rent-Equipment & Vehicles			9,643	9,643		9,643	(1,213)	8,430			35
36	Other (specify):*											36
37	TOTAL Ownership			129,073	129,073		129,073	(8,903)	120,170			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					80,630	80,630		80,630			39
40	Barber and Beauty Shops		452	12,961	13,413		13,413		13,413			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee					36,135	36,135		36,135			42
43	Other (specify):*											43
44	TOTAL Special Cost Centers		452	12,961	13,413	116,765	130,178		130,178			44
	GRAND TOTAL COST											
45	(sum of lines 29, 37 & 44)	1,795,765	369,686	1,103,554	3,269,005		3,269,005	(21,326)	3,247,679			45

^{*}Attach a schedule if more than one type of cost is included on this line, or if the total exceeds \$1000.

Facility Name & ID Number MASON CITY AREA NURSING HOME

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	Amount	Refer- ence	OHF USE ONLY	1 03
1	Day Care	\$	ence	\$	1
2	Other Care for Outpatients	Ψ		Ψ	2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(1,213)	35		5
6	Rented Facility Space	(2,429)	34		6
7	Sale of Supplies to Non-Patients	(2):2)			7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation		30		9
10	Interest and Other Investment Income	(2,744)	32	1	10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax		2		13
14	Non-Care Related Interest		32		14
15	Non-Care Related Owner's Transactions		33		15
16	Personal Expenses (Including Transportation)		24		16
17	Non-Care Related Fees	(60)	20		17
18	Fines and Penalties				18
19	Entertainment	(3,186)	24		19
20	Contributions		27		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers	(1,385)	19		22
23	Malpractice Insurance for Individuals				23
24	Bad Debt		27		24
25	Fund Raising, Advertising and Promotional	(7,792)	20		25
	Income Taxes and Illinois Personal		,		
26	Property Replacement Tax				26
27					27
	Yellow Page Advertising	(3.518)	77		28
29	Other-Attach Schedule Real Estate Taxes	(2,517)	33	Φ.	29
30	SUBTOTAL (A): (Sum of lines 1-29)	\$ (21,326)		\$	30

Ol	HF USE ONLY				
48	49	50	51	52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below. (See instructions.)

2

		Amount	Reference	
31	Non-Paid Workers-Attach Schedule*	\$		31
32	Donated Goods-Attach Schedule*			32
	Amortization of Organization &			
33	Pre-Operating Expense			33
	Adjustments for Related Organization			
34	Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	\$		36
	(sum of SUBTOTALS			
37	TOTAL ADJUSTMENTS (A) and (B))	\$ (21,326	6)	37

^{*}These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		Yes	No	Amount	Reference	
38	Medically Necessary Transport.			\$		38
39						39
40	Gift and Coffee Shops					40
	Barber and Beauty Shops					41
	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	TOTAL (C): (sum of lines 38-46)			\$		47

Page 5A

MASON CITY AREA NURSING HOME

| ID# | 0034256 | | Report Period Beginning: 1/01/05 | Ending: 12/31/05 |

Sch. V Line
NON-ALLOWABLE EXPENSES Amount Reference

	NON-ALLOWABLE EXPENSES		Amount	Reference	
1		\$			1
2					2
3					3
4					4
5			(1,213)	35	5
6			(2,429)	34	6
7					7
8					8
9			0	30	9
10				32	10
11					11
12					12
13			0	2	13
14				32	14
15			0	33	15
16				24	16
17			(60)	20	17
18					18
19				24	19
20			0	27	20
21					21
22			(1,385)	19	22
23					23
24			0	27	24
25			(7,792)	20	25
26					26
27					27
28					28
29			(2,517)	33	29
30					30
31					31
32					32
33					33
34					34
35					35
36					36
37					37
38					38
39					39
40					40
41					41
42					42
43					43
44					44
45		+			45
46		1			46
47					47
48		+			48
48	Total	-	(15,396)		48
49	IVIAI		(15,596)		49

Summary A # 0034256 Report Period Beginning: 1/01/05 **Ending:** 12/31/05

Facility Name & ID Number MASON CITY AREA NURSING HOME SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6 D	6E	6F	6 G	6H	6I	(to Sch V, col	I.7)
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	TOTAL General Services	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	TOTAL Health Care and Programs	0	0	0	0	0	0	0	0	0	0	0	0	10
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	(1,385)	0	0	0	0	0	0	0	0	0	0	(1,385)	19
20	Fees, Subscriptions & Promotions	(7,852)	0	0	0	0	0	0	0	0	0	0	(7,852)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	2
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	(3,186)	0	0	0	0	0	0	0	0	0	0	(3,186)	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	2
28	TOTAL General Administration	(12,423)	0	0	0	0	0	0	0	0	0	0	(12,423)) 2
	TOTAL Operating Expense													
29	(sum of lines 8,16 & 28)	(12,423)	0	0	0	0	0	0	0	0	0	0	(12,423)	2

Summary B # 0034256 **Report Period Beginning:** 12/31/05 **Facility Name & ID Number** MASON CITY AREA NURSING HOME 1/01/05 Ending:

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

													SUMMARY	
	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	TOTALS	1
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6 G	6H	6I	(to Sch V, col.	.7)
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(2,744)	0	0	0	0	0	0	0	0	0	0	(2,744)	32
33	Real Estate Taxes	(2,517)	0	0	0	0	0	0	0	0	0	0	(2,517)	33
34	Rent-Facility & Grounds	(2,429)	0	0	0	0	0	0	0	0	0	0	(2,429)	34
35	Rent-Equipment & Vehicles	(1,213)	0	0	0	0	0	0	0	0	0	0	(1,213)	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	TOTAL Ownership	(8,903)	0	0	0	0	0	0	0	0	0	0	(8,903)	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	TOTAL Special Cost Centers	0	0	0	0	0	0	0	0	0	0	0	0	44
	GRAND TOTAL COST													
45	(sum of lines 29, 37 & 44)	(21,326)	0	0	0	0	0	0	0	0	0	0	(21,326)	45

0034256

MASON CITY AREA NURSING HOME

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1			2	3					
OWN	ERS	RELATE	D NURSING HOMES		OTHER RELA	RELATED BUSINESS ENTITIES			
Name Ownership %		Name	City			City	Type o	of Business	
See Attached									

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth.

| XX | YES | NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

	1	2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
	1	4	5 Cost Fer General Leager	4	5 Cost to Related Organization	0	/		
						Percent	Operating Cost	Adjustments for	
Scho	edule V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
					0	Ownership	Organization	Costs (7 minus 4)	
1	V			¢		Ownership	¢	¢	1
1	V			Þ				Φ	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total	otal \$			\$	\$ *	14		

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS								
Facility Name & ID Number	MASON CITY AREA NURSING HOME	#	0034256	Report Period Beginning:	1/01/05	Ending:	12/31/05	
VII. RELATED PARTIES (continue B. Are any costs included in this i management fees, purchase of	report which are a result of transactions with related organizations? This	is includes rent, VO						

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:
						Percent	Operating Cost	Adjustments for
Schedu	ıle V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization
						Ownership	Organization	Costs (7 minus 4)
15	V			\$		Ownership	\$	\$ 15
16	V			Ψ		<u> </u>	Ψ	16
17	V							17
18	V							18
19	V							19
20	V							20
21	\mathbf{V}							21
22	\mathbf{V}							22
23	\mathbf{V}							23
24	\mathbf{V}							24
25	${f V}$							25
26	\mathbf{V}							26
27	V							27
28	V							28
29	V							29
30	V							30
31	V							31
32	V							32
33	V							33
34	V							34
35	V							
36 37	V					-		36
38	V					-		38
39 To	otal			\$			 \$	\$ *

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

STATE OF ILLINOIS								
Facility Name & ID Number	MASON CITY AREA NURSING HOME	#	0034256	Report Period Beginning:	1/01/05	Ending:	12/31/05	
VII. RELATED PARTIES (conti	,							
B. Are any costs included in th	is report which are a result of transactions with related orga	nizati <u>ons? T</u> his includes rent	,					
management fees, purchase	of supplies, and so forth.	NO						
If ves costs incurred as a re	sult of transactions with related organizations must be fully	itemized in accordance with						

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1		2	3 Cost Per General Ledger	4	5 Cost to Related Organization	6	7	8 Difference:	
		Ī				Percent	Operating Cost	Adjustments for	
Schedu	ıle V	Line	Item	Amount	Name of Related Organization	of	of Related	Related Organization	
						Ownership	Organization	Costs (7 minus 4)	
15	V			\$		100.00%			15
16	V						·		16
17	V								17
18	V								18
19	V								19
20	V								20
21	V								21
22	V								22
23	V								23
24	V								24
25	\mathbf{V}								25
26	\mathbf{V}								26
27	\mathbf{V}								27
28	\mathbf{V}								28
29	V								29
30	V								30
31	V								31
32	V								32
33	V								33
34	V								34
35	V								35
36	V				,				36
37	V								37
38	V					L			38
39 To	otal			\$			\$ 0	\$ *	39

^{*} Total must agree with the amount recorded on line 34 of Schedule VI.

Page 7

Ending:

12/31/05

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5		5	7		8	
						Average Hou	ırs Per Work				
					Compensation		oted to this	Compensation		Schedule V.	
					Received	Facility and % of Total		in Costs for this		Line &	
				Ownership	From Other	Work	Week	Reporting Period**		Column	
	Name	Title	Function	Interest	Nursing Homes*	Hours	Percent	Description	Amount	Reference	
1									\$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	\$		13

^{*} If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

^{**} This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

STATE	OF	HI	IN	OI
DIALL	$\mathbf{O}\mathbf{r}$		/II.	v

Page 8 # 0034256 Report Period Beginning: Facility Name & ID Number MASON CITY AREA NURSING HOME 1/01/05 **Ending:** 12/31/05

VIII. ALLOCATION OF INDIRECT COSTS

	Name of Related Organization	
A. Are there any costs included in this report which were derived from allocations of central office	Street Address	
or parent organization costs? (See instructions.) YES NO xx	City / State / Zip Code	
	Phone Number ()	
B. Show the allocation of costs below. If necessary, please attach worksheets.	Fax Number ()	

B. Show the allocation of costs below. If necessary, please attach worksheets.

	1 Schedule V	2	3 Unit of Allocation	4	5 Number of	ndirect	7 Amount of Salary	8	9	
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Being	Cost Contained	Facility	Allocation	
		T4		TD - 4 - 1 TJ - *4	_					
1	Reference	Item	Square Feet)	Total Units	Allocated Among	cated	in Column 6	Units	(col.8/col.4)x col.6	1
1						\$	\$		\$	1
2										2
3			+							3
5										5
6			+							6
7										7
8			+							8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23										23
24							_		±	24 25
25	TOTALS					\$	\$		\$	25

		Δ T	TT	T Th	
STA	. н. н.				
1717		\/ 1	111		

IS Page 8A

0034256 Report Period Beginning: **Facility Name & ID Number** MASON CITY AREA NURSING HOME 1/01/05 **Ending:** 12/31/05 VIII. ALLOCATION OF INDIRECT COSTS Name of Related Organization **Street Address** A. Are there any costs included in this report which were derived from allocations of central office City / State / Zip Code Phone Number or parent organization costs? (See instructions.) YES NO B. Show the allocation of costs below. If necessary, please attach worksheets. Fax Number

	1	2	3	4	5	6	7	8	9	
	Schedule V		Unit of Allocation		Number of	Total Indirect	Amount of Salary			
	Line		(i.e.,Days, Direct Cost,		Subunits Being	Cost Being	Cost Contained	Facility	Allocation	
	Reference	Item	Square Feet)	Total Units	Allocated Among	Allocated	in Column 6	Units	(col.8/col.4)x col.6	
1						\$	\$		\$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10			-							10
11 12										11
13										12 13
			<u> </u>							14
14 15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22 23
23	_									23
24										24
25	TOTALS					\$	\$		\$	25

					STATE OI	F ILLINOIS				Page 9	
Facil	ity Name & ID Number	MASON CIT	ΓY AREA NURSING HOME	#	0034256	Report Period	Beginning:	1/01/05	Ending:	12/31/05	
	IX. INTEREST EXPENSE AN	D DEAL EST	ATE TAY EVDENCE								
			***	4 1 1 1 1 1	p .	`					
	A. Interest: (Complete deta		ovided for each loan - attach a se	parate scnedule ii							
	1	2	3	4	5	6	7	8	9	10	
										Reporting	
				Monthly				Maturity	Interest	Period	
	Name of Lender	Related**	Purpose of Loan	Payment	Date of	Amou	ınt of Note	Date	Rate	Interest	
		YES NO	-	Required	Note	Original	Balance		(4 Digits)	Expense	
	A. Directly Facility Related	128 118		Hequirea	11000	Oliginai	Durance		(121gitts)	Empense	
	· ·	-									
	Long-Term				•	A	I &	1		•	
1						\$	\$			\$	1
2											2
3											3
4											4
5											5
	Working Capital										
6											6
7											7
8											8

10

11

12

13

14

15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V.	' . \$	Line #
--	---------------	--------

9 TOTAL Facility Related
B. Non-Facility Related*

14 TOTAL Non-Facility Related

15 TOTALS (line 9+line14)

10 Interest Income

11

12

13

^{*} Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

^{**} If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

STATE OF ILLINOIS

0034256 Report Period Beginning: 1/01/05 Ending: 12/31/05

Facility Name & ID Number MASON CITY AREA NURSING HOME

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

	Important, please see the next worksheet, "	'RE Tay" The real	estate tay statement and					
1. Real Estate Tax accrual used on 2004 report.	bill must accompany the cost report.	TC_Tax . The real	estate tax statement and	s	1			
1. Real Estate Tax decidal asea on 2001 report.	•							
2. Real Estate Taxes paid during the year: (Indicate the	tax year to which this payment applies. If payment cover	rs more than one year, de	tail below.)	\$	2			
3. Under or (over) accrual (line 2 minus line 1).				\$	3			
4. Real Estate Tax accrual used for 2005 report. (Detail	il and explain your calculation of this accrual on the lines	below.)		\$	4			
5. Direct costs of an appeal of tax assessments which h	as NOT been included in professional fees or other generation	al operating costs on Sch	nedule V, sections A, B or C.					
(Describe appeal cost below. Attach cop	ies of invoices to support the cost and a cop	y of the appeal file	d with the county.)	\$	5			
6. Subtract a refund of real estate taxes. You must offs classified as a real estate tax cost plus one-half of an TOTAL REFUND \$ For	• • • • • • • • • • • • • • • • • • • •	al estate tax appeal	board's decision.)	\$	6			
7. Real Estate Tax expense reported on Schedule V, lin	e 33. This should be a combination of lines 3 thru 6.			\$	7			
Real Estate Tax History:								
Real Estate Tax Bill for Calendar Year: 2000			FOR OHF USE ONLY					
2001 2002	2 10	13	FROM R. E. TAX STATEMENT F	FOR 2004 \$	13			
2003 2004		14	PLUS APPEAL COST FROM LIN	NE 5 \$	14			
		15	LESS REFUND FROM LINE 6	\$	15			
		16	AMOUNT TO USE FOR RATE C.	ALCULATION \$	16			

NOTES:

- 1. Please indicate a negative number by use of brackets(). Deduct any overaccrual of taxes from prior year.
- 2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

C. Tax Bills

tax bill which is normally paid during 2005.

TO: Long Term Care Facilities with Real Estate Tax Rates RE: 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FAC	ILITY NAME	MASON CITY AF	REA NURSING HOMI	3	COUNTY	Mason	
FAC	ILITY IDPH LICE	ENSE NUMBER	0034256				
CON	TACT PERSON I	REGARDING THIS	REPORT				
TEL	EPHONE ()		FAX #: ()		
A.	·	al Estate Tax Cost					
	cost that applies t home property w	to the operation of the	state tax assessed for 20 e nursing home in Colu to other organizations cost for any period oth	ımn D. Real esta , or used for purp	te tax applicable to oses other than lon	any portion	of the nursing
	(A)	(B)		(C)		(D)
	Tax Index	<u>Number</u>	Property Descri	<u>ption</u>	<u>Total Tax</u>		Tax Applicable to Nursing Hom
1.					\$	\$_	
2.					\$	\$	
3.					\$	\$	
4.					\$		
5.					\$	\$_	
6.					\$		
7.					\$	\$	
8.					\$	\$	
9.					\$	\$	
10.		<u> </u>			\$	\$_	
				TOTALS	\$	\$	
B.	Real Estate Tax	Cost Allocations					
	Does any portion used for nursing l		to more than one nursi xx YES	ng home, vacant p	property, or proper	ty which is r	not directly
			edule which shows the				ome.

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004

Page 10A

F:1	E4 No P. ID. No I MACONI C	TTX7 A T	DEA NUDCINIC HOME		STATE OF ILLIN			1/0-	1/05 E 4:	Page 11 12/31/05
	ity Name & ID Number MASON C UILDING AND GENERAL INFOR				# 003423	oo Keport P	eriod Beginning:	1/0.	1/05 Ending:	12/31/05
A.	Square Feet: 34,	102	B. General Construction Type:	Exterior	Brick/Wood	Frame	Wood	Number •	of Stories	1
C.	Does the Operating Entity?	<u> </u>	(a) Own the Facility		ı a Related Organiza			(c) Rent from Organiza	n Completely Unition.	related
	(Facilities checking (a) or (b) mus	t compl	ete Schedule XI. Those checking (c)	may complete Sched	ule XI or Schedule X	II-A. See inst	ructions.)			
D.	Does the Operating Entity?	XX	(a) Own the Equipment	(b) Rent equi	pment from a Relate	d Organizatio	n.		ipment from Con l Organization.	npletely
	(Facilities checking (a) or (b) mus	t compl	ete Schedule XI-C. Those checking	(c) may complete Sch	edule XI-C or Sched	ule XII-B. See	instructions.)	Officiated	Organization.	
Е.	(such as, but not limited to, apart	ments, a	his operating entity or related to the ssisted living facilities, day training footage, and number of beds/units	g facilities, day care, in	ndependent living fac					
F.	Does this cost report reflect any o If so, please complete the followin		tion or pre-operating costs which a	re being amortized?			YES	xx NO		
1.	. Total Amount Incurred:				2. Number of Year	s Over Which	it is Being Amor	rtized:		
3	. Current Period Amortization:				4. Dates Incurred:		way.			
		Na	ture of Costs:							
			(Attach a complete schedule deta	iling the total amount	t of organization and	pre-operating	g costs.)			
XI. C	OWNERSHIP COSTS:									
			1	2	3		4			
	A. Land.	1	Use	Square Feet	Year Acquire	d	Cost	1		
		$\frac{1}{2}$				3	36,000	$\frac{1}{2}$		
		3	TOTALS			\$	36,000	3		

Page 12 12/31/05

Facility Name & ID Number MASON CITY AREA NURSING HOME # 0034256 Report Period Beginning: 1/01/05 Ending:

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1	nig Depreciation-including Fixed Equ	2	3	4	5	6	7	8	9	
		FOR BHF USE ONLY	Year	Year		Current Book	Life	Straight Line		Accumulated	
	Beds*		Acquired	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
4	97				\$ 2,605,181	\$		\$	\$	\$	4
5											5
6											6
7											7
8											8
		ovement Type**									
	1990 Improve			1990	7,990						9
	1991 Improve			1991	16,512						10
	1992 Improve			1992	22,678						11
	1993 Improve			1993							12
	1994 Improve			1994	24,788						13
	1995 Improve	ements		1995	17,777						14
15											15
	Water Heater			1997	4,800						16
17	Asphalt Seale	er		1997	5,395						17
	Entrance & V			1997	1,700						18
	Landscaping			1997	6,770						19
20											20
	Kitch Centra			1996	15,800						21
		Administrative Offices		1996	2,500						22
23	Landscapping	g		1996	2,710						23
	Automatic Do	oor Closers		1996	3,732						24
25											25
	Life Safety A			1998	992						26
	Sound Systen			1998	1,442						27
	Security System	e m		1998	10,742						28
29				1000							29
	Parking Lot			1999	4,190						30
	Petroleum tai	nk		1999	12,500						31
32											32
33											33
	C/O Allocatio					04.05		0.4.052		1 0// 252	34
	Book Depreci	ation				94,976		94,976		1,266,353	35
36											36

^{*}Total beds on this schedule must agree with page 2.

See Page 12A, Line 70 for total

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12A 12/31/05 STATE OF ILLINOIS MASON CITY AREA NURSING HOME Facility Name & ID Number 0034256 **Report Period Beginning: Ending:** 1/01/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
37 Firewallsceilling		\$ 10,800	\$		\$	\$	\$	3'
38 Facility RemodelMaterials (Carpeting)	2000	22,660						38
39								39
40 Wallpaper	2001	5,552						40
41 Carpet Installation	2001	4,141						4
42 Woodwork Refinishing	2001	418						4:
43 Water Heater	2001	6,125						4.
44 Facility RemodelLabor	2001	1,520						4
45 Parking Lot	2001	9,375						4:
46 Living room Remodel	2001	415						40
47 Facility RemodelMaterials	2001	23,795						4'
48 Ceramic Tile Shower	2001	698						48
49 Hot Water Pump	2001	2,586						49
50 Carpeting and Installation	2001	2,208						50
51 Wander Guard	2001	1,270						51
52 Light Fixtures and Door	2001	2,777						52
53 Flooring	2001	1,311						5.
54								5
55 Painting	2002	1,500						5:
56 Remodel & Update Nurses Station	2002	13,224						5
57 Decorative consulting	2002	3,982						5'
58 Living room Remodel	2002	493						58
59								59
60 Remodel & Update Nurses Station	2003	14,461						60
61 Roof	2003	10,085						62
62 Window Treatments	2003	1,484						62
63 Water Heater	2003	6,355						6.
64 Heater/Air Conditioning Unit	2003	1,095						64
65 Rim Device	2003	1,290						65
66 Drywall	2003	2,817						60
67 Flooring								6
68								68
69								69
70 TOTAL (lines 4 thru 69)		\$ 2,920,636	\$ 94,976		\$ 94,976	\$	\$ 1,266,353	70

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12B 12/31/05 STATE OF ILLINOIS MASON CITY AREA NURSING HOME Facility Name & ID Number 0034256 **Report Period Beginning: Ending:** 1/01/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

B. Building Depreciation-Including Fixed Equipment. (Se	3	4	5	6	7	8	9	Т
	Year		Current Book	Life	Straight Line		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12A, Carried Forward		\$ 2,920,636	\$ 94,976		\$ 94,976	\$	\$ 1,266,353	1
2								2
3 Wall Coverings	2004	1,392						3
4 Walkin Cooler/Freezer	2004	21,245						4
5								5
6 Condenser	2005	2,106						6
7 Door Alarm	2005	2,059						7
8 Smoke Alarm	2005	3,732						8
9 Parking lot resurface	2005	21,715						9
10 Fire Alarm	2005	2,267						10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18								18 19
20								20
21								21
22								22
23								23
24							+	24
25							+	25
26								26
27								27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,975,152	\$ 94,976		\$ 94,976	\$	\$ 1,266,353	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

Page 12C 12/31/05 STATE OF ILLINOIS MASON CITY AREA NURSING HOME Facility Name & ID Number 0034256 **Report Period Beginning: Ending:** 1/01/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

1	3	4	5	6	7	8	9	
	Year		Current Book	Life	Straight Line Depreciation		Accumulated	
Improvement Type**	Constructed	Cost	Depreciation	in Years	Depreciation	Adjustments	Depreciation	
1 Totals from Page 12B, Carried Forward		\$ 2,975,152	\$ 94,976		\$ 94,976	\$	\$ 1,266,353	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
12								12
13								13
14								14
15								15
16								16
17								17
18 19								18 19
20								20
21								21
22								22
23							+	23
24								24
25								25
26								26
27							 	27
28								28
29								29
30								30
31								31
32								32
33								33
34 TOTAL (lines 1 thru 33)		\$ 2,975,152	\$ 94,976		\$ 94,976	\$	\$ 1,266,353	34

^{**}Improvement type must be detailed in order for the cost report to be considered complete.

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SIAIR	VF I		1015

Page 13 Facility Name & ID Number MASON CITY AREA NURSING HOME **Report Period Beginning:** 12/31/05 0034256 1/01/05 **Ending:**

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	ov Equipment 2 oprovides and an arrange	Transportation (see instructions)						
	Category of	1	Current Book	Straight Line	4	Component	Accumulated	
	Equipment	Cost	Depreciation 2	Depreciation 3	Adjustments	Life 5	Depreciation 6	
71	Purchased in Prior Years	\$ 509,965	\$ 19,193	\$ 19,193	\$		\$ 451,620	71
72	Current Year Purchases	15,887						72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	\$ 525,852	\$ 19,193	\$ 19,193	\$		\$ 451,620	75

D. Vehicle Depreciation (See instructions.)*

	1	Model, Make	Year	4	Current Book	Straight Line	7	Life in	Accumulated	
	Use	and Year 2	Acquired 3	Cost	Depreciation 5	Depreciation 6	Adjustments	Years 8	Depreciation 9	
76				\$	\$	\$	\$		\$	76
77										77
78										78
79										79
80	TOTALS			\$	\$	\$	\$		\$	80

E. Summary of Care-Related Assets

		Reference		Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	\$	3,537,004	81	L
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	\$	114,169	82	:
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	\$	114,169	83	*
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	\$		84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	\$	1,717,973	85	,

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1	2	Current Book	Accumulated	
	Description & Year Acquired	Cost	Depreciation 3	Depreciation 4	
86	Independent Living Center	\$ 591,233	\$	\$	86
87					87
88					88
89					89
90					90
91	TOTALS	\$ 591,233	\$	\$	91

G. Construction-in-Progress

	Description	Cost	
92		\$	92
93			93
94			94
95		\$	95

Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

This must agree with Schedule V line 30, column 8.

						STA'	TE OF ILLINOIS						Page 14
Faci	lity Name & II	D Number	MASON CITY A	REA NURSING HO	<u>OME</u>	#	0034256	Repor	t Period 1	Beginning:	1/01/05	Ending:	12/31/05
XII.	 Name of I Does the f 	nd Fixed Equip Party Holding I		ons.) addition to rental am	ount shown below	on line 7,]no					
		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount		5 Total Years of Lease	6 Total Years Renewal Option*	:				
3 4 5	Original Building: Additions			\$					3 4 5	10. Effective of Beginning Ending	dates of curren	t rental agreei 	nent:
6	TOTAL			\$	**				6 7	11. Rent to be rental agr	e paid in future reement:	years under t	he current
	This amou	unt was calcula ngth of the lease	ted by dividing the t	ense included on pag otal amount to be an NO Tei			*			Fiscal Year 12. 13. 14.	/2006 /2007 /2008	Annual Ro	ent
	15. Is Moval	ble equipment 1	ansportation and Fix rental included in bu vable equipment:		instructions.) Description	n:	YES]NO					
	C. Vehicle Re	ental (See instru	- ictions.)				(Attach a schedu	le detailing the brea	akdown o	f movable equipn	nent)		
	1 Use		2 Model Year and Make		3 nthly Lease Payment		4 Rental Expense for this Period			* If there	is an option to	buy the buildi	ing,
17 18 19				\$		\$		17 18 19		please p schedule	rovide complet e.	e details on at	tached
20	TOTAL.			ф		ф		20			ount plus any a		
21	TOTAL			\$		\$		21		<u>expense</u>	must agree wit	in page 4, line	<u>34.</u>

Facility N	Name & ID Number MASON CITY ARE	A NURSING HOME			#	0034256	Report Period Beginning:	1/01/05	Ending:	12/31/05
XIII. EX	PENSES RELATING TO CERTIFIED NURSE AID	E (CNA) TRAINING	PROGRAMS (See	e instructions.)						
A. 7	TYPE OF TRAINING PROGRAM (If CNAs are trai	ned in another facility	program, attach a	a schedule listing	the facility	name, addr	ess and cost per CNA trained in	that facility.))	
	1. HAVE YOU TRAINED CNAs	YES 2.	CLASSROOM	I PORTION:			3. CLINICAL PO	ORTION:		
	DURING THIS REPORT									
	PERIOD?	NO	IN-HOUSE PR	ROGRAM			IN-HOUSE PR	OGRAM		
			IN OTHER FA	ACILITY			IN OTHER FA	CILITY		
	If "yes", please complete the remainder of this schedule. If "no", provide an		COMMUNITY	Y COLLEGE			HOURS PER (CNA		
	explanation as to why this training was									
	not necessary.		HOURS PER	CNA						
	B. EXPENSES									
В. Е	EXPENSES	ALLOCATIO	ON OF COSTS	(d)			C. CONTRACTUAL II	NCOME		
В. Е	EXPENSES	ALLOCATI	ON OF COSTS	(d)					amount of in	come vour
В. Е	EXPENSES	ALLOCATI		(d) 3		4	In the box belo	w record the a		
В. Е	EXPENSES	1	ON OF COSTS 2 cility			4		w record the a		
В. Е	EXPENSES	1	2			4 Total	In the box belo	w record the a		
B. F	Community College Tuition	1 Fac	2 cility	3	\$	-	In the box belo facility received	w record the a		
B. F	Community College Tuition Books and Supplies	1 Fac	2 cility	3	\$	-	In the box belo	w record the a		
B. F	Community College Tuition Books and Supplies Classroom Wages (a)	1 Fac	2 cility	3	\$	-	In the box belo facility received \$ D. NUMBER OF CNAS	w record the a		
B. F	Community College Tuition Books and Supplies Classroom Wages (a) Clinical Wages (b)	1 Fac	2 cility	3	\$	-	In the box belo facility received	w record the a		
B. F	Community College Tuition Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c)	1 Fac	2 cility	3	\$	-	In the box belo facility received \$ D. NUMBER OF CNAS COMPLET 1. From this fac	w record the add training CNA STRAINED TED cility		
B. F	Community College Tuition Books and Supplies Classroom Wages (a) Clinical Wages (b)	1 Fac	2 cility	3	\$	-	In the box belo facility received \$ D. NUMBER OF CNAS	w record the add training CNA STRAINED TED cility		
1 2 3 4 5	Community College Tuition Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c) Transportation Contractual Payments	1 Fac	2 cility	3	\$	-	In the box belo facility received \$ D. NUMBER OF CNAS COMPLET 1. From this fact 2. From other for DROP-OU	w record the and training CNA STRAINED FED Collity Cacilities (f)		
1 2 3 4 5	Community College Tuition Books and Supplies Classroom Wages (a) Clinical Wages (b) In-House Trainer Wages (c) Transportation	1 Fac	2 cility	3	\$	-	In the box belo facility received \$ D. NUMBER OF CNAS COMPLET 1. From this fact 2. From other factors	w record the and training CNA STRAINED FED Collity Cacilities (f)		

- (a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
- (b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
- (c) For in-house training programs only. Do not include fringe benefits.

(e)

10 SUM OF line 9, col. 1 and 2

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs.

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

Page 15

- (e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.
- (f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

MASON CITY AREA NURSING HOME

STATE OF ILLINOIS

0034256 Report Period Beginning: 1/01/05

Page 16

12/31/05

Ending:

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

Facility Name & ID Number

	, ,	1	2	3	4	5	6	7	8	
		Schedule V	Staf	Staff Outside Practitioner		Outside Practitioner				
	Service	Line & Column	Units of	Cost	(other than consultant)		(Actual or)	Total Units	Total Cost	
		Reference	Service		Units	Cost	Allocated)	(Column 2 + 4)	(Col. $3 + 5 + 6$)	
1	Licensed Occupational Therapist		hrs	\$		\$ 53,002	\$	9	\$ 53,002	1
	Licensed Speech and Language									
2	Development Therapist		hrs			9,636			9,636	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs			91,023	985		92,008	4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
			# of							
9	Pharmacy		prescrpts				63,104		63,104	9
	Psychological Services									
	(Evaluation and Diagnosis/									
10	Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):					17,526			17,526	13
14	TOTAL			\$		\$ 171,187	\$ 64,089		\$ 235,276	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be listed on this schedule.

0034256 Report Period Beginning: 1/01/05 Ending: 12/31/05

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 12/31/05 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1		2 After	
		0	perating	Consolidation*	
	A. Current Assets				
1	Cash on Hand and in Banks	\$	312,217	\$	1
2	Cash-Patient Deposits		5,836		2
	Accounts & Short-Term Notes Receivable-				
3	Patients (less allowance)		358,497		3
4	Supply Inventory (priced at)				4
5	Short-Term Investments				5
6	Prepaid Insurance		67,742		6
7	Other Prepaid Expenses				7
8	Accounts Receivable (owners or related parties)				8
9	Other(specify):				9
	TOTAL Current Assets				
10	(sum of lines 1 thru 9)	\$	744,292	\$	10
	B. Long-Term Assets				
11	Long-Term Notes Receivable				11
12	Long-Term Investments				12
13	Land		83,500		13
14	Buildings, at Historical Cost		3,058,043		14
15	Leasehold Improvements, at Historical Cost				15
16	Equipment, at Historical Cost		525,853		16
17	Accumulated Depreciation (book methods)		(1,730,324)		17
18	Deferred Charges				18
19	Organization & Pre-Operating Costs				19
	Accumulated Amortization -				
20	Organization & Pre-Operating Costs				20
21	Restricted Funds				21
22	Other Long-Term Assets (specify):				22
23	Other(specify):				23
	TOTAL Long-Term Assets				
24	(sum of lines 11 thru 23)	\$	1,937,072	\$	24
	,		. ,		
	TOTAL ASSETS				
25	(sum of lines 10 and 24)	\$	2,681,364	\$	25

		1 O _J	perating	2 After Consolidation*	
	C. Current Liabilities				
26	Accounts Payable	\$	65,163	\$	26
27	Officer's Accounts Payable				27
28	Accounts Payable-Patient Deposits		5,836		28
29	Short-Term Notes Payable				29
30	Accrued Salaries Payable		134,600		30
	Accrued Taxes Payable				
31	(excluding real estate taxes)		15,582		31
32	Accrued Real Estate Taxes(Sch.IX-B)		2,549		32
33	Accrued Interest Payable		50		33
34	Deferred Compensation				34
35	Federal and State Income Taxes				35
	Other Current Liabilities(specify):				
36	Other				36
37					37
	TOTAL Current Liabilities				
38	(sum of lines 26 thru 37)	\$	223,780	\$	38
	D. Long-Term Liabilities				
39	Long-Term Notes Payable				39
40	Mortgage Payable		29,202		40
41	Bonds Payable				41
42	Deferred Compensation				42
	Other Long-Term Liabilities(specify):				
43					43
44					44
	TOTAL Long-Term Liabilities				
45	(sum of lines 39 thru 44)	\$	29,202	\$	45
	TOTAL LIABILITIES				
46	(sum of lines 38 and 45)	\$	252,982	\$	46
47	TOTAL EQUITY(page 18, line 24)	\$	2,428,382	\$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	\$	2,681,364	\$	48

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*(See instructions.)

STATE OF ILLI		
0034256	Report Period Beginning:	1/01/05

Page 18 12/31/05

Ending:

3	TATE OF ILLIN	OIS
#	0034256	Repor
	1	
\$	2,484,944	1
		2
		3
		4
		5
\$	2,484,944	6
	(56,562)	7
		8
		9
		10
		11
		12
()	13
		14
		15
		16
\$	(56,562)	17
		18
		19
		20
		21
		22
\$		23
\$	2,428,382	24
	# \$ \$ ((# 0034256 1 Total \$ 2,484,944 \$ (56,562) () \$ (56,562)

^{*} This must agree with page 17, line 47.

Report Period Beginning:

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

		1	
	Revenue	Amount	
	A. Inpatient Care		
1	Gross Revenue All Levels of Care	\$ 3,285,013	1
2	Discounts and Allowances for all Levels	(581,040)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	\$ 2,703,973	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	324,629	6
7	Oxygen		7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	\$ 324,629	8
	C. Other Operating Revenue		
9	Payments for Education		9
	Other Government Grants		10
	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	16,087	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	2,429	16
17	Sale of Drugs	135,827	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	\$ 154,343	23
	D. Non-Operating Revenue	,	
24	Contributions		24
25	Interest and Other Investment Income***	4,022	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	\$ 4,022	26
	E. Other Revenue (specify):****	, , , , , , , , , , , , , , , , , , ,	
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	\$	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	\$ 3,186,967	30

	o agamet expenses	2	
	Expenses	Amount	
	A. Operating Expenses		
31	General Services	679,968	31
32	Health Care	1,531,086	32
33	General Administration	915,465	33
	B. Capital Expense		
34	Ownership	129,073	34
	C. Ancillary Expense		
35	Special Cost Centers	13,413	35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37	Non Nursing Home Expenses	(25,476)	37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	\$ 3,243,529	40
41	Income before Income Taxes (line 30 minus line 40)**	(56,562)	41
42	Income Taxes	·	42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	\$ (56,562)	43

*	This must	agree with pag	ze 4. line 45	. column 4.
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** Does this agree with taxable income (loss) per Federal Income
Tax Return? _____ If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

^{****}Provide a detailed breakdown of "Other Revenue" on an attached sheet.

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

	(This schedule must cover the	entire reporting				
		1	2**	3	4	
		# of Hrs.	# of Hrs.	Reporting Period	Average	
		Actually	Paid and	Total Salaries,	Hourly	
		Worked	Accrued	Wages	Wage	
1	Director of Nursing	1,868	2,080	\$ 57,774	\$ 27.78	1
2	Assistant Director of Nursing			0		2
3	Registered Nurses	7,911	8,443	158,892	18.82	3
4	Licensed Practical Nurses	18,390	19,912	336,181	16.88	4
5	CNAs & Orderlies	46,172	50,717	494,576	9.75	5
6	CNA Trainees			0		6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	5,521	6,027	70,840	11.75	8
9	Activity Director					9
10	Activity Assistants	5,613	5,828	52,017	8.93	10
11	Social Service Workers	1,518	1,566	17,272	11.03	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook					14
	Cook Helpers/Assistants	23,136	25,017	207,708	8.30	15
16	Dishwashers					16
17	Maintenance Workers	5,005	5,763	56,567	9.82	17
	Housekeepers	7,778	8,278	68,907	8.32	18
19	Laundry	5,573	5,906	50,981	8.63	19
20	Administrator	2,000	2,080	65,554	31.52	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	9,239	10,102	158,496	15.69	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Beautician	1,000	1,000	0	0.00	33
34	TOTAL (lines 1 - 33)	140,724	152,719	\$ 1,795,765 *	\$ 11.76	34

^{*} This total must agree with page 4, column 1, line 45.

B. CONSULTANT SERVICES

		1	2	3	
		Number	Total Consultant	Schedule V	
		of Hrs.	Cost for	Line &	
		Paid &	Reporting	Column	
		Accrued	Period	Reference	
35	Dietary Consultant		\$ 0		35
36	Medical Director		9,000		36
37	Medical Records Consultant		925		37
38	Nurse Consultant				38
39	Pharmacist Consultant		550		39
40	Physical Therapy Consultant				40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant		0		45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)		\$ 10,475		49

C. CONTRACT NURSES

		1	2	3	
		Number		Schedule V	
		of Hrs.	Total	Line &	
		Paid &	Contract	Column	
		Accrued	Wages	Reference	
50	Registered Nurses	0	\$ 0		50
51	Licensed Practical Nurses	0	0		51
52	Certified Nurse Assistants/Aides	0	0		52
53	TOTAL (lines 50 - 52)		\$		53

^{**} See instructions.

		STATE OF ILLING	STATE OF ILLINOIS					
Facility Name & ID Number	MASON CITY AREA NURSING HOME	# 0034256	Report Period Beginning:	1/01/05	Ending: 12/31/05			

XIX. SUPPORT SCHEDULES											
A. Administrative Salaries		Ownership			D. Employee Benefits and Payr				F. Dues, Fees, Subscriptions and Promotion	ons	
Name	Function	%	Ar	mount	Description			Amount	Description		Amount
Joyce Conrady			\$	65,554	Workers' Compensation Insura		\$_	40,974	IDPH License Fee	\$	1,990
					Unemployment Compensation	Insurance	_	11,307	Advertising: Employee Recruitment		2,015
					FICA Taxes		_	137,376	Health Care Worker Background Check		
					Employee Health Insurance			158,583	(Indicate # of checks performed		460
					Employee Meals				Central Office Allocation		
					Illinois Municipal Retirement I	Fund (IMRF)*			Promotional Advertising		686
					Employee Hepatitis Vaccine			0	Public Relations		7,106
TOTAL (agree to Schedule V, lin	e 17, col. 1)				Employee Benefits -			36,531	Dues and Subscriptions		6,229
(List each licensed administrator	separately.)		\$	65,554	Employee Benefits - central office	ce			License and Fees		710
B. Administrative - Other											
							_		Less: Public Relations Expense		(7,106)
Description			Ar	mount			_		Non-allowable advertising		(60)
-			\$				_		Yellow page advertising		(686)
							_		1 0		
					TOTAL (agree to Schedule V,		\$	384,771	TOTAL (agree to Sch. V,	\$	11,344
					line 22, col.8)		=	· · · · · · · · · · · · · · · · · · ·	line 20, col. 8)	_	
TOTAL (agree to Schedule V, lin	ne 17, col. 3)		\$		E. Schedule of Non-Cash Comp	ensation Paid			G. Schedule of Travel and Seminar**		
(Attach a copy of any manageme		nt)			to Owners or Employees						
C. Professional Services		/							Description		Amount
Vendor/Payee	Type		Ar	mount	Description	Line#		Amount	F		
Heritage Enterprises	Mgt Fee			102,000	2 compaign	2	\$	111104111	Out-of-State Travel	\$	
Abbott % Co	Audit		Ψ	5,200			Ψ_		Out of State Travel	Ψ_	
1100011 70 00	Tuuit			0			_				
				0			_		In-State Travel		
				<u> </u>			_		In-State Havei	_	3,211
							_			_	154
							_			_	154
							_		Coming Tempona	_	1 020
							_		Seminar Expense		1,820
		_					_			_	(3,186)
7 1 1 1 1 1 7 7				1 205			_	_		_	
LegalAdjusted to Zero				1,385			_			, —	
	10			0					Entertainment Expense	(_)
TOTAL (agree to Schedule V, lin					TOTAL		\$_		(agree to Sch. V,		
(If total legal fees exceed \$2500 ar	ttach copy of invoic	es.)	\$	108,585					TOTAL line 24, col. 8)	\$	1,999

^{*} Attach copy of IMRF notifications

^{**}See instructions.

STA	ATE OF	ILLINOIS				Page 22
	#	0034256	Report Period Reginning	1/01/05	Ending.	12/31/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3). (See instructions.)

Facility Name & ID Number MASON CITY AREA NURSING HOME

	(See instructions.)												
	1	2	3	4	5	6	7	8	9	10	11	12	13
		Month & Year						Amount of	Expense Amor	tized Per Year			
	Improvement	Improvement	Total Cost	Useful									
	Type	Was Made		Life	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			\$		\$	\$	\$	\$	\$	\$	\$	\$	\$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		\$		\$	\$	\$	\$	\$	\$	\$	\$	\$

Facility	y Name & ID Number MASON CITY AREA NURSING HOME	STATE OF #	ILLINOIS 0034256	Report Period Beginning:	1/01/05	Ending:	Page 23 12/31/05
XX. G	ENERAL INFORMATION:						
	Are nursing employees (RN,LPN,NA) represented by a union? no			applies and services which are of the addition to the daily rate, been proper		be billed to	
(2)	Are there any dues to nursing home associations included on the cost report? If YES, give association name and amount. Illinois Healthcare Association		•	tion of Schedule V? yes	_		c
(3)	Did the nursing home make political contributions or payments to a political action organization? yes If YES, have these costs been properly adjusted out of the cost report? yes	the is a	e patient census li a portion of the b	uilding used for any function other sted on page 2, Section B? yes uilding used for rental, a pharmacy, plains how all related costs were al	day care, etc.)	For example of YES, attack	e,
(4)	Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? no If YES, what is the capacity?	on	dicate the cost of Schedule V. lated costs?			been offset ag	
(5)	Have you properly capitalized all major repairs and equipment purchases? What was the average life used for new equipment added during this period? yes 7 years		avel and Transpor		no		
(6)	Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. \$	b. 1	If YES, attach a c	complete explanation. parate contract with the Department If YES, please indicate the			
(7)	Have all costs reported on this form been determined using accounting procedures consistent with prior reports? yes If NO, attach a complete explanation.	c.	program during the What percent of a	nis reporting period. \$ Ill travel expense relates to transpor ge logs been maintained? yes			
(8)	Are you presently operating under a sale and leaseback arrangement? If YES, give effective date of lease.	e	Are all vehicles stimes when not in	tored at the nursing home during the			
(9)	Are you presently operating under a sublease agreement? YES xx N	O	out of the cost rep		_		no
(10)	Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO xx If YES, please indicate name of the facili IDPH license number of this related party and the date the present owners took over.	ty,	Indicate the an transportation	nount of income earned from p during this reporting period.	roviding suc	ch \$	_
		Fir	rm Name: Ab	erformed by an independent certifie bott & Co	•	The instruct	tions for the
(11)	Indicate the amount of the Provider Participation Fees paid and accrued to the Department during this cost report period. \$ 36,135 This amount is to be recorded on line 42 of Schedule V.		st report require the en attached?	hat a copy of this audit be included If no, please explain.	Report not		s copy
(12)	Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? no If YES, attach an explanation of the allocation.	ou	t of Schedule V?	n do not relate to the provision of lo		-	
		pe	rformed been atta	e in excess of \$2500, have legal invoched to this cost report? a summary of services for all archi		-	ices

	berto.	GL I	indep 64 inquig lim	period (period	in a particular		AMERICA MANAGEMENT	
=	CARRIED BOX						Memory March 1997 (1997) (1997	
100	MEDICAN INCOMES	104,407				100	LON ACCULARCIO ANC LON ACCULARCIO ANA	
100	MERCAN CONTROLS					100	LIN ACCUMENTATION AS	
110	CASE IN BOOK PAYROCK ACCOUNTS INCOME AND INCOME.					1,300	Lincolnia Harvan (Chili	
130	PROPERTY OF THE PARTY OF T	47,742				1,50	Line Carte Societies	
130	POGE-DOUDSDAY SCHOOLSTONY					1,400	LINE CAND STORY COLUMN	
120	PERSONAL A RECEMBER	GUAD HELOS				120	LOTCOR ALL DRIVE	
100	MCE DOG & BENEVISIADOS ACCOM DEPENDAÇÃOS	AUTOMA AUTOMA				1,00	LANGEMENT OF	
100	LOADING PLACE	1,652				1,00	LAN COMPANY OF THE PARTY OF THE	
101	DESCRIPTION OF THE PERSONNELS.					3,000	DIRECTOR PAYABLE LINE ACCRECATE ATTACK	
306	BOSE RECEIVED	20,000				3,000	THE CHARLEST AND THE	
310 300	SCHOOL VACATION OF	.46,467				3,430	LINES TORRESONALE LINESCHALL JUNE	
30K 300	PECA TAX PAYMENT PET PAYMENT	.1(02	.1(02			3,180	SAN CLASS WIR THE PARTMEN	
316	E-MAND RECORD MESCENSE SCHOOL MESCENSE					2,200 2,200	Lame Could be a Casa Annual Casa Annual Could be a Casa Annual Casa	
226 226	MANUFACTURES					23H	SAM CREEKE POOR SAM CREEKE PROTECTION CONTENTS	
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250 250	ACCRESS DOCUMENT PAYABLE DESCRIPTION OF THE PAYABLE	- 1				3,96	Limited Bill Line	
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